ONLINE APPENDIXES 2C

# Ambulatory surgical centers

ONLINE APPENDIX 2C-A

# Revisions to the ambulatory surgical center payment system in 2008

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required the Secretary to implement a revised payment system for services furnished in ambulatory surgical centers (ASCs). CMS satisfied this legal requirement by launching a revised payment system on January 1, 2008.

The MMA also directed the Government Accountability Office (GAO) to conduct a study comparing the relative costs of procedures performed in ASCs with the relative costs of procedures performed in hospital outpatient departments (HOPDs) (Government Accountability Office 2006). Reflecting in part the results of GAO's study, the revised payment system that CMS began using on January 1, 2008, included a number of substantive changes:

- The services eligible for separate payment under the ASC payment system increased substantially in number and in scope.
- The relative payment amounts for most services are based on the relative payment amounts in the outpatient prospective payment system (PPS). However, in some instances the payment amounts are limited by the payment amounts from the Medicare physician fee schedule (MPFS).
- The share of a service's payment rate adjusted for geographic variation in labor costs increased from 34.45 percent to 50 percent.

## Substantial increase in the number of services eligible for payment under the revised ASC payment system

CMS increased the number of services eligible for separate payment under the revised ASC payment system through two mechanisms. First, CMS revised the criteria a surgical procedure must meet to be eligible for payment. This revision is consistent with a previous Commission recommendation (Medicare Payment Advisory Commission 2004). Second, CMS expanded the types of service for which an ASC can receive separate payment to include radiology services, brachytherapy sources, some drugs, and some implantable devices. Previously, these items were either packaged into the payment for surgical procedures or paid under a different Medicare fee schedule.

In general, CMS has decided that any surgical procedure represented by a Current Procedural Terminology code in the range 10000 through 69999 can be eligible for payment under the ASC payment system. This list includes procedures predominantly performed in physician offices (office-based procedures), which were excluded under the old ASC payment system. However, in the interest of patient safety, CMS excludes surgical procedures that have one or more of the following characteristics:

- generally result in extensive blood loss,
- require major or prolonged invasion of body cavities,
- directly involve major blood vessels,
- are emergent or life-threatening in nature,
- commonly require systemic or thrombolytic therapy,
- are designated as requiring inpatient care,
- involve the patient generally requiring active medical monitoring and care at midnight following the procedure.

In addition, CMS chose to pay separately for some services that are paid separately under the outpatient PPS, which include:

- radiology services when they are integral to a covered surgical procedure,
- brachytherapy sources implanted during a surgical procedure covered under the ASC system,
- all drugs that are paid separately under the outpatient PPS when provided in association with a surgical procedure covered under the ASC system, and
- devices with pass-through status in the outpatient PPS that are implanted during a surgical procedure covered under the ASC system.

## Relative payment weights largely based on outpatient PPS

Most surgical procedures have a relative weight that indicates the relative costliness of furnishing the procedure. In general, the relative weight for a surgical procedure is based on its relative weight in the outpatient PPS, with two exceptions: office-based procedures and

device-intensive procedures in which the cost of an implantable device is at least 50 percent of the outpatient PPS cost of the entire procedure. For an office-based procedure, CMS first determines whether the procedure's payment rate is smaller under the practice expense portion of the MPFS or the amount derived from outpatient PPS relative weight. If the amount from the MPFS is smaller, the MPFS amount is the payment rate for the procedure and CMS assigns no relative weight. If the amount based on the outpatient PPS is smaller, the procedure's relative weight is its relative weight on the outpatient PPS.

For a device-intensive procedure, CMS uses the following method to develop ASC relative weights:

- Divide the procedure's payment rate from the outpatient PPS into two parts—the service portion and the device portion. The device portion is equal to the device cost included in the outpatient PPS payment rate. The service portion is equal to the remainder of the outpatient PPS payment rate after removing the device portion.
- Adjust the service portion by a ratio of the ASC conversion factor and the outpatient PPS conversion factor.
- Determine an ASC payment rate as the sum of the device portion and the adjusted service portion.
- Develop a relative weight as the payment rate divided by the ASC conversion factor.

CMS distinguishes between the service portion and the device portion because the agency believes the cost of providing a service is lower in ASCs than in HOPDs, but the cost of obtaining a device is about the same for ASCs and HOPDs.

CMS creates a payment rate for each ASC procedure as a product of its relative weight and a conversion factor. Each year, CMS sets the conversion factor so that total program payments under the revised payment system equal total program payments for 2007, plus an update of 1.2 percent for 2010. For 2010, the conversion factor is $41.87. ■

ONLINE APPENDIX 2C-B

# The hospital market basket and Medicare Economic Index

CMS developed the hospital market basket and Medicare Economic Index (MEI) to track changes in input prices for hospital and physician services, respectively. Each market basket is a fixed-weight index that measures the change over time in the prices of a consistent mix of goods and services purchased by providers. The construction of a market basket involves three steps:

1. CMS estimates providers' spending for a set of specific cost categories in a base period and calculates each category's share of total spending (its cost weight);
2. CMS matches each cost category to a price or wage variable (its price proxy);
3. Finally, CMS multiplies each cost weight by its price proxy; the sum of these products equals the market basket level for a given time period.

## Hospital market basket

The hospital market basket tracks changes in hospitals' inpatient operating costs; a separate index (the capital input price index) measures changes in hospitals' capital costs. Operating costs account for 92.4 percent of total hospital costs and capital costs account for the remaining 7.6 percent (Centers for Medicare & Medicaid Services 2009). In step one, CMS primarily used hospital cost reports from 2006 to determine the cost categories and cost weights for the market basket for hospital operating costs (Centers for Medicare & Medicaid Services 2009).[1] CMS developed seven cost categories from the cost reports: wages and salaries, employee benefits, contract labor, pharmaceuticals, malpractice insurance, blood and blood products, and a residual category of all other costs. The category of all other costs was divided into smaller groups using data from the Bureau of Economic Analysis (BEA). Table 2C-B1 displays the major cost categories and their weights; for example, the cost weight for wages and salaries is 47.2 percent. In step two, CMS selected wage and price proxies for each cost category to measure price changes over time. The price proxies are based on data from the Bureau of Labor Statistics (BLS). For example, the price proxy for wages and salaries is the employment cost index (ECI) for wages and salaries for civilian hospital workers. In step three, CMS multiplies each category's cost weight by its price proxy. For example, the cost weight for wages and salaries is multiplied by the ECI for wages and salaries for civilian hospital workers. The sum of these products across all categories yields the market basket level for a given time period. CMS divides the market basket level for a given time period by the market basket level for an earlier period to determine the change in the price index over time. CMS followed a similar process in developing the capital input price index.

**TABLE 2C–B1**

**Cost categories and weights from market basket for hospital operating costs**

| Major cost category | Cost weight |
|---|---|
| Compensation | |
| Wages and salaries | 47.2% |
| Employee benefits | 12.4 |
| Utilities | 2.2 |
| Professional liability insurance | 1.7 |
| All other | |
| All other products | 19.5 |
| Labor-related services | 9.2 |
| Non-labor-related services | 7.9 |
| Total | 100 |

Note: Total may not sum to 100 percent due to rounding. Hospital operating costs account for 92.4 percent of total hospital costs. The cost categories and cost weights are derived from 2006 hospital cost reports and Benchmark Input–Output data from the Bureau of Economic Analysis.

Source: Centers for Medicare & Medicaid Services 2009.

## Medicare Economic Index

The Medicare Economic Index (MEI) tracks price changes in the inputs used to produce physician services. It comprises two categories: physicians' own time (52.5 percent of the total) and physicians' practice expenses (47.5 percent) (Centers for Medicare & Medicaid Services 2003). The practice expense category includes wages, salaries, and benefits for nonphysician staff; office expenses, such as rent and utilities; medical materials and supplies; professional liability insurance; medical equipment; prescription drugs; and other expenses, such as accounting, legal, and office management services. We focus on the practice expense portion of the MEI because it includes the types of inputs that ASCs are likely to use.

In step one, CMS used data from the 2003 American Medical Association (AMA) Patient Care Physician Survey, which measures physician earnings and overall practice costs for 2000, to determine the cost categories and weights for total expenses, physician earnings, and professional liability insurance (Centers for Medicare & Medicaid Services 2003). CMS used other data sources from the BEA, BLS, AMA, and the Census Bureau to further disaggregate these expenses into subcategories.[2] For example, office expenses account for 25.7 percent of total practice expenses. Table 2C-B2 displays all the practice expense cost categories and their weights. In step two, CMS selected price proxies for each cost category to measure price changes over time. As with the hospital market basket, the price proxies are based on BLS data. For example, the price proxy for office expenses is the consumer price index for all urban consumers (CPI–U) for housing. In step three, CMS multiplies each category's cost weight (such as office expenses) by its price proxy (such as the CPI–U for housing). The sum of these products across all categories yields the level of the MEI for a given time period. As with the hospital market basket, CMS determines the change in the MEI over time by dividing the MEI level for a given time period by the MEI level for an earlier period. Unlike the hospital market basket, the MEI includes an adjustment for multifactor productivity growth based on the 10-year moving average of productivity growth in the private nonfarm business sector. ■

**TABLE 2C–B2**

**Cost categories and weights from practice expense portion of MEI**

| Cost category | Cost weight |
|---|---|
| Nonphysician employee compensation: | |
| Wages and salaries | 29.0% |
| Benefits | 10.2 |
| Office expenses | 25.7 |
| Professional liability insurance | 8.1 |
| Medical equipment | 4.3 |
| Pharmaceuticals and medical materials and supplies | 9.1 |
| Other expenses | 13.5 |
| Total | 100 |

Note: MEI (Medicare Economic Index). Total may not sum to 100 percent due to rounding. The weights are based on data from the 2003 American Medical Association Patient Care Physician Survey and other sources. The table excludes the weights for physician earnings and CMS's productivity adjustment. The table rescales the practice expense cost weights published by CMS to sum to 100. The nonphysician employee compensation wages and salaries category includes separate weights for professional and technical workers, managers, clerical workers, and service workers.

Source: Centers for Medicare & Medicaid Services 2003.

## Endnotes

1 CMS uses cost reports from hospitals paid under the inpatient prospective payment system (IPPS) and excludes non-IPPS hospitals.

2 The other data sources include prior AMA surveys, the BEA's 1997 Benchmark Input-Output table, BLS's 2003 Employment Cost Index, and the Census Bureau's 2002 Current Population Survey.

# References

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